

**HOUSE . . . . . No. 4009**

---

**The Commonwealth of Massachusetts**

\_\_\_\_\_  
**In the One Hundred and Ninetieth General Court  
(2017-2018)**  
\_\_\_\_\_

An Act relative to advancing contraceptive coverage and economic security in our state (ACCESS).

*Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:*

1           SECTION 1. Chapter 32A of the General Laws, as appearing in the 2014 Official  
2 Edition, is hereby amended by inserting after section 27 the following section:

3           Section 28. (a) Any coverage offered by the commission to any active or retired  
4 employee of the commonwealth insured under the group insurance commission shall provide  
5 coverage for all of the following services and contraceptive methods:

6           (1) all Food and Drug Administration ("FDA")-approved contraceptive drugs, devices  
7 and other products; provided that coverage shall not be required for male condoms or FDA-  
8 approved oral contraceptive drugs with no therapeutic equivalent. The following apply:

9           (i) Where the FDA has approved one or more therapeutic equivalents of a contraceptive  
10 drug, device, or product, the Commission is not required to include all such therapeutically  
11 equivalent versions in its formulary, as long as at least one is included and covered without cost-  
12 sharing and in accordance with this section; and

13 (ii) If there is a therapeutic equivalent of a drug, device, or other product for an FDA-  
14 approved contraceptive method, the Commission may provide coverage for more than one drug,  
15 device, or other product and may impose cost-sharing requirements as long as at least one drug,  
16 device, or other product for that method is available without cost-sharing; provided that if an  
17 individual's attending provider recommends a particular FDA-approved contraceptive, based on  
18 a medical determination with respect to that individual, the insurer shall provide coverage,  
19 subject to the Commission's utilization management procedures, for the prescribed contraceptive  
20 drug, device, or product without cost-sharing.

21 (2) all FDA-approved emergency contraception available over-the-counter, either with a  
22 prescription, or dispensed consistent with the requirements of section 19A of chapter 94C;

23 (3) prescription contraceptives intended to last: (i) for up to a 3-month period for the first  
24 time the prescription contraceptive is dispensed to the covered person; and (ii) for up to a 12-  
25 month period for any subsequent dispensing of the same prescription, which may be dispensed  
26 all at once or over the course of the 12-month period, regardless of whether the covered person  
27 was enrolled in a plan or policy under this chapter at the time the prescription contraceptive was  
28 first dispensed; provided, however, that the insured may not fill more than one 12-month  
29 prescription in a single dispensing per plan year;

30 (4) voluntary female sterilization procedures;

31 (5) patient education and counseling on contraception; and

32 (6) follow-up services related to the drugs, devices, products and procedures covered  
33 under this subsection, including, but not limited to, management of side effects, counseling for  
34 continued adherence, and device insertion and removal.

35 (b) (1) Coverage provided under this subsection shall not be subject to any deductible,  
36 coinsurance, copayment or any other cost-sharing requirement, except as provided in paragraph  
37 (a)(1)(i)-(ii) or as otherwise required under federal law. Any coverage offered under this section  
38 shall not impose any unreasonable restrictions or delays in the coverage; provided that  
39 reasonable medical management techniques may be applied to coverage within a method  
40 category, as defined by the FDA, but not across types of methods.

41 (2) Benefits for an enrollee under this section shall also be provided for such enrollee's  
42 covered spouse and covered dependents.

43 (3) Nothing in this section shall be construed to exclude coverage for contraceptive drugs,  
44 devices, products and procedures as prescribed by a provider for reasons other than contraceptive  
45 purposes, such as for decreasing the risk of ovarian cancer or eliminating symptoms of  
46 menopause or for contraception that is necessary to preserve the life or health of such enrollee, or  
47 such enrollee's covered spouse, and/or covered dependents.

48 (4) The group insurance commission shall ensure plan compliance with this chapter.

49 (5) Nothing in this section shall be construed to require the commission to cover  
50 experimental or investigational treatments.

51 (c) For purposes of this section, the following definitions shall apply, unless the context  
52 clearly requires otherwise:

53 "Provider", an individual or facility licensed, certified, or otherwise authorized or  
54 permitted by law to administer health care in the ordinary course of business or professional  
55 practice acting within the scope of that license.

56           Contraceptive drugs, devices, or products classified as “therapeutic equivalents” means  
57 (1) they are approved as safe and effective; and (2) they are pharmaceutical equivalents in that  
58 they (a) contain identical amounts of the same active drug ingredient in the same dosage form  
59 and route of administration, and (b) meet compendial or other applicable standards of strength,  
60 quality, purity, and identity; provided further that to be considered a “therapeutic equivalent”, the  
61 contraceptive drugs, devices, or products must be assigned the same therapeutic equivalence  
62 code by the FDA.

63           SECTION 2. Chapter 118E of the General Laws, as so appearing, is hereby amended by  
64 inserting after section 10I the following section:

65           10J (a) The division and its contracted health insurers, health plans, health maintenance  
66 organizations, behavioral health management firms and third-party administrators under contract  
67 to a Medicaid managed care organization or primary care clinician plan shall provide coverage  
68 for all of the following services and contraceptive methods:

69           (1) all FDA-approved contraceptive drugs, devices and other products, provided that  
70 coverage shall not be required for male condoms or FDA-approved oral contraceptives with no  
71 therapeutic equivalent. The following apply:

72           (i) Where the FDA has approved one or more therapeutic equivalents of a contraceptive  
73 drug, device, or product, the division is not required to include all such therapeutically equivalent  
74 versions in its formulary, so long as at least one is included and covered without cost-sharing in  
75 accordance with this section;

76           (ii) If there is a therapeutic equivalent of a drug, device, or other product for an FDA-  
77 approved contraceptive method, the division may provide coverage for more than one drug,

78 device, or other product and may impose cost-sharing requirements as long as at least one drug,  
79 device, or other product for that method is available without cost-sharing; provided, however,  
80 that if an individual's attending provider recommends a particular FDA-approved contraceptive,  
81 based on a medical determination with respect to that individual, the division shall provide  
82 coverage, subject to the division's utilization management procedures, for the prescribed  
83 contraceptive drug, device, or product without cost-sharing; and

84 (iii) Appeals of an adverse determination of a request for coverage of an alternative  
85 FDA-approved contraceptive drug, device, or other product without cost-sharing shall be subject  
86 to the grievance process laid out in section 47 of chapter 118E;

87 (2) all FDA-approved emergency contraception available over-the-counter, either with a  
88 prescription, or dispensed consistent with the requirements of section 19A of chapter 94C;

89 (3) prescription contraceptives intended to last: (i) for up to a 3-month period for the first  
90 time the prescription contraceptive is dispensed to the covered person; and (ii) for up to a 12-  
91 month period for any subsequent dispensing of the same prescription, which may be dispensed  
92 all at once or over the course of the 12-month period, regardless of whether the covered person  
93 was enrolled with the division at the time the prescription contraceptive was first dispensed;  
94 provided, however, that the insured may not fill more than one 12-month prescription in a single  
95 dispensing per plan year;

96 (4) voluntary female sterilization procedures;

97 (5) patient education and counseling on contraception; and

98 (6) follow-up services related to the drugs, devices, products and procedures covered  
99 under this subsection, including, but not limited to, management of side effects, counseling for  
100 continued adherence, and device insertion and removal.

101 (b) (1) Coverage provided under this section shall not be subject to any deductible,  
102 coinsurance, copayment or any other cost-sharing requirement, except as provided for in  
103 paragraph (a)(1)(i)-(ii), or as otherwise required under federal law. Any coverage provided  
104 under this section shall not impose any unreasonable restrictions or delays in the coverage;  
105 provided that reasonable medical management techniques may be applied to coverage within a  
106 method category, as defined by the FDA, but not across types of methods.

107 (2) Benefits for an enrollee under this section shall be the same for such enrollee's  
108 covered spouse and covered dependents.

109 (3) Nothing in this section shall be construed to exclude coverage for contraceptive drugs,  
110 devices, products and procedures prescribed by a provider for reasons other than contraceptive  
111 purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause  
112 or for contraception that is necessary to preserve the life or health of such enrollee, or such  
113 enrollee's covered spouse and/or covered dependents.

114 (4) Nothing in this section shall be construed to deny or restrict in any way the division of  
115 medical assistance's authority to ensure its contracted health insurers, health plans, health  
116 maintenance organizations, behavioral health management firms and third-party administrators  
117 under contract to a Medicaid managed care organization or primary care clinician plan are in  
118 compliance with this chapter.

119 (5) Nothing in this section shall be construed to require the division to cover experimental  
120 or investigational treatments.

121 (c) For purposes of this section, the following definitions shall apply, unless the context  
122 clearly requires otherwise:

123 “Provider”, an individual or facility licensed, certified, or otherwise authorized or  
124 permitted by law to administer health care in the ordinary course of business or professional  
125 practice acting within the scope of that licensure.

126 Contraceptive drugs, devices, or products classified as “therapeutic equivalents” means  
127 (1) they are approved as safe and effective; and (2) they are pharmaceutical equivalents in that  
128 they (a) contain identical amounts of the same active drug ingredient in the same dosage form  
129 and route of administration, and (b) meet compendial or other applicable standards of strength,  
130 quality, purity, and identity; provided further that to be considered a “therapeutic equivalent”, the  
131 contraceptive drugs, devices, or products must be assigned the same therapeutic equivalence  
132 code by the FDA.

133 SECTION 3. Chapter 175 of the General Laws, as so appearing, is hereby amended by  
134 inserting after section 47W(c) the following:

135 (d) An individual policy of accident and sickness insurance issued pursuant to section  
136 108 that provides hospital expense and surgical expense and any group blanket policy of accident  
137 and sickness insurance issued pursuant to section 110 that provides hospital expense and surgical  
138 expense insurance, delivered, issued or renewed by agreement between the insurer and the  
139 policyholder, within or without the Commonwealth, (hereinafter “policy”) shall provide benefits  
140 for residents of the Commonwealth and all group members having a principal place of

141 employment within the Commonwealth coverage for all of the following services and  
142 contraceptive methods:

143 (1) all FDA-approved contraceptive drugs, devices and other products, provided that  
144 coverage shall not be required for male condoms or FDA-approved oral contraceptive drugs with  
145 no therapeutic equivalent. The following apply:

146 (i) Where the FDA has approved one or more therapeutic equivalents of a contraceptive  
147 drug, device, or product, a policy is not required to include all such therapeutically equivalent  
148 versions in its formulary, as long as at least one is included and covered without cost-sharing and  
149 in accordance with this section;

150 (ii) If there is a therapeutic equivalent of a drug, device, or other product for an FDA-  
151 approved contraceptive method, a policy may provide coverage for more than one drug, device,  
152 or other product and may impose cost-sharing requirements as long as at least one drug, device,  
153 or other product for that method is available without cost-sharing; provided, however, that if an  
154 individual's attending provider recommends a particular FDA-approved contraceptive, based on  
155 a medical determination with respect to that individual, the policy shall provide coverage, subject  
156 to that policy's utilization management procedures, for the prescribed contraceptive drug, device,  
157 or product without cost-sharing; and

158 (iii) Appeals of an adverse determination of a request for coverage of an alternative FDA-  
159 approved contraceptive drug, device, or other product without cost-sharing shall be subject to the  
160 expedited grievance process under section 13 of chapter 176O;

161 (2) all FDA-approved emergency contraception available over-the-counter, either with a  
162 prescription, or dispensed consistent with the requirements of section 19A of chapter 94C;

163 (3) prescription contraceptives intended to last for: (i) up to a 3-month period for the first  
164 time the prescription contraceptive is dispensed to the covered person; and (ii) for up to a 12-  
165 month period for any subsequent dispensing of the same prescription, which may be dispensed  
166 all at once or over the course of the 12-month period, regardless of whether the covered person  
167 was enrolled in the policy at the time the prescription was first dispensed; provided, however,  
168 that a corporation shall not be required to provide coverage for more than one 12-month  
169 prescription in a single dispensing per plan year;

170 (4) voluntary female sterilization procedures;

171 (5) patient education and counseling on contraception; and

172 (6) follow-up services related to the drugs, devices, products and procedures covered  
173 under this section, including, but not limited to, management of side effects, counseling for  
174 continued adherence, and device insertion and removal.

175 (e) (1) Coverage provided under this section shall not be subject to any deductible,  
176 coinsurance, copayment or any other cost-sharing requirement, except as provided for un  
177 paragraph (d)(1)(i)-(ii) or as otherwise required under federal law. Any covered offered under  
178 this section shall not impose any unreasonable restrictions or delays on the coverage, in  
179 accordance with the requirements of chapter 176O; provided that reasonable medical  
180 management techniques may be applied to coverage within a method category, as defined by the  
181 FDA, but not across types of methods.

182 (2) Benefits for an enrollee shall be the same for such enrollee's covered spouse and  
183 covered dependents.

184 (f)(1) This section may not apply to a policy if such policy is purchased by an employer  
185 that is a church or qualified church-controlled organization, at the request of the employer.

186 (2) A church or qualified church-controlled organization that invokes the exemption  
187 provided under subsection (f)(1) shall provide written notice to prospective enrollees prior to  
188 enrollment with the plan, listing the contraceptive health care methods and services such  
189 employer refuses to cover for religious reasons.

190 (g) Nothing in this section shall be construed to exclude coverage for contraceptive drugs,  
191 devices, products and procedures prescribed by a provider for reasons other than contraceptive  
192 purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause  
193 or for contraception that is necessary to preserve the life or health of an enrollee.

194 (h) The commissioner of insurance shall ensure compliance with this chapter.

195 (i) Nothing in this section shall be construed to require an individual or group policy of  
196 accident or sickness to cover experimental or investigational treatments.

197 (j) For purposes of this section, the following definitions shall apply, unless the context  
198 clearly requires otherwise:

199 “Church”, a church, a convention or association of churches, or an elementary or  
200 secondary school which is controlled, operated, or principally supported by a church or by a  
201 convention or association of churches.

202 “Provider”, an individual or facility licensed, certified, or otherwise authorized or  
203 permitted by law to administer health care in the ordinary course of business or professional  
204 practice acting within the scope of that licensure.

205 “Qualified church-controlled organization”, described in section 501(c)(3) of the Internal  
206 Revenue Code, other than an organization which--

207 (i) offers goods, services, or facilities for sale, other than on an incidental basis, to the  
208 general public, other than goods, services, or facilities which are sold at a nominal charge which  
209 is substantially less than the cost of providing such goods, services, or facilities; and

210 (ii) normally receives more than 25 percent of its support from either (I) governmental  
211 sources, or (II) receipts from admissions, sales of merchandise, performance of services, or  
212 furnishing of facilities, in activities which are not unrelated trades or businesses, or both.

213 Contraceptive drugs, devices, or products classified as “therapeutic equivalents” means  
214 (1) they are approved as safe and effective; and (2) they are pharmaceutical equivalents in that  
215 they (a) contain identical amounts of the same active drug ingredient in the same dosage form  
216 and route of administration, and (b) meet compendial or other applicable standards of strength,  
217 quality, purity, and identity; provided further that to be considered a “therapeutic equivalent”, the  
218 contraceptive drugs, devices, or products must be assigned the same therapeutic equivalence  
219 code by the FDA.

220 SECTION 4. Chapter 176A of the General Laws, as so appearing, is hereby amended by  
221 inserting after section 8W(c) the following:

222 (d) Any contract between a subscriber and the corporation under an individual or group  
223 hospital service plan that is delivered, issued or renewed within or without the Commonwealth  
224 and that provides benefits for outpatient services shall provide to all individual subscribers and  
225 members within the Commonwealth and to all group members having a principal place of

226 employment within the Commonwealth coverage for all of the following services and  
227 contraceptive methods:

228 (1) all FDA-approved contraceptive drugs, devices and other products, provided that  
229 coverage shall not be required for male condoms or FDA-approved oral contraceptive drugs with  
230 no therapeutic equivalent. The following apply:

231 (i) Where the FDA has approved one or more therapeutic equivalents of a contraceptive  
232 drug, device, or product, an individual or group hospital service plan is not required to include all  
233 such therapeutically equivalent versions in its formulary, as long as at least one is included and  
234 covered without cost-sharing and in accordance with this section;

235 (ii) If there is a therapeutic equivalent of a drug, device, or other product for an FDA-  
236 approved contraceptive method, an individual or group hospital service plan may provide  
237 coverage for more than one drug, device, or other product and may impose cost-sharing  
238 requirements as long as at least one drug, device, or other product for that method is available  
239 without cost-sharing; provided, however, that if an individual's attending provider recommends a  
240 particular FDA-approved contraceptive, based on a medical determination with respect to that  
241 individual, the insurer shall provide coverage, subject to a plan's utilization management  
242 procedures, for the prescribed contraceptive drug, device, or product without cost-sharing; and

243 (iii) Appeals of an adverse determination of a request for coverage of an alternative FDA-  
244 approved contraceptive drug, device or other product without cost sharing shall be subject to the  
245 expedited grievance process under section 13 of chapter 176O;

246 (2) all FDA-approved emergency contraception available over-the-counter, either with a  
247 prescription, or dispensed consistent with the requirements of section 19A of chapter 94C;

248 (3) prescription contraceptives intended to last: (i) for up to a 3-month period for the first  
249 time the prescription contraceptive is dispensed to the covered person; and (ii) for up to a 12-  
250 month period for any subsequent dispensing of the same prescription, which may be dispensed  
251 all at once or over the course of the 12-month period, regardless of whether the covered person  
252 was enrolled in the policy, contract, or plan at the time the prescription contraceptive was first  
253 dispensed; provided, however, that a corporation shall not be required to provide coverage for  
254 more than one 12-month prescription in a single dispensing per plan year;

255 (4) voluntary female sterilization procedures;

256 (5) patient education and counseling on contraception; and

257 (6) follow-up services related to the drugs, devices, products and procedures covered  
258 under this subsection, including, but not limited to, management of side effects, counseling for  
259 continued adherence, and device insertion and removal.

260 (e) (1) Coverage provided under this section shall not be subject to any deductible,  
261 coinsurance, copayment or any cost-sharing requirement, except as provided for in paragraph  
262 (d)(1), or as otherwise required under federal law. Any coverage offered under this section shall  
263 not impose any unreasonable restrictions or delays in the coverage, in accordance with the  
264 requirements of Chapter 176O; provided that reasonable medical management techniques may  
265 be applied to coverage within a method category, as defined by the FDA, but not across types of  
266 methods.

267 (2) Benefits for an enrollee under this subsection shall be the same for an enrollee's  
268 covered spouse and covered dependents.

269 (f) (1) The requirements of subsection (d) may not apply to a contract between a  
270 subscriber and a corporation under an individual or group hospital service plan that is delivered,  
271 issued, or renewed within or without the Commonwealth that is purchased by an employer that is  
272 a church or qualified church-controlled organization, at the request of the employer.

273 (2) A church or qualified church-controlled organization that invokes the exemption  
274 provided under subsection (f)(1) shall provide written notice to prospective enrollees prior to  
275 enrollment with the plan, listing the contraceptive health care methods and services such  
276 employer refuses to cover for religious reasons.

277 (g) Nothing in this subsection shall be construed to exclude coverage for contraceptive  
278 drugs, devices, products and procedures prescribed by a provider for reasons other than  
279 contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of  
280 menopause or for contraception that is necessary to preserve the life or health of an enrollee.

281 (h) The commissioner of insurance shall ensure compliance with this chapter.

282 (i) Nothing in this section shall be construed to require a contract to cover experimental  
283 or investigational treatments.

284 (j) For purposes of this section, the following definitions shall apply, unless the context  
285 clearly requires otherwise:

286 “Church”, a church, a convention or association of churches, or an elementary or  
287 secondary school which is controlled, operated, or principally supported by a church or by a  
288 convention or association of churches.

289 “Provider”, an individual or facility licensed, certified, or otherwise authorized or  
290 permitted by law to administer health care in the ordinary course of business or professional  
291 practice acting within the scope of that licensure.

292 “Qualified church-controlled organization”, described in section 501(c)(3) of the Internal  
293 Revenue Code, other than an organization which--

294 (i) offers goods, services, or facilities for sale, other than on an incidental basis, to the  
295 general public, other than goods, services, or facilities which are sold at a nominal charge which  
296 is substantially less than the cost of providing such goods, services, or facilities; and

297 (ii) normally receives more than 25 percent of its support from either (I) governmental  
298 sources, or (II) receipts from admissions, sales of merchandise, performance of services, or  
299 furnishing of facilities, in activities which are not unrelated trades or businesses, or both.

300 Contraceptive drugs, devices, or products classified as “therapeutic equivalents” means  
301 (1) they are approved as safe and effective; and (2) they are pharmaceutical equivalents in that  
302 they (a) contain identical amounts of the same active drug ingredient in the same dosage form  
303 and route of administration, and (b) meet compendial or other applicable standards of strength,  
304 quality, purity, and identity; provided further that to be considered a “therapeutic equivalent”, the  
305 contraceptive drugs, devices, or products must be assigned the same therapeutic equivalence  
306 code by the FDA.

307 SECTION 5. Chapter 176B of the General Laws, as so appearing, is hereby amended by  
308 inserting after section 4W(c) the following:

309 (d) Any subscription certificate under an individual or group medical service agreement  
310 that is delivered, issued or renewed within or without the Commonwealth and that provides  
311 benefits for outpatient services shall provide to all individual subscribers and members within the  
312 Commonwealth and to all group members having a principal place of employment within the  
313 Commonwealth coverage for all of the following services and contraceptive methods:

314 (1) all FDA-approved contraceptive drugs, devices and other products, provided that  
315 coverage shall not be required for male condoms or FDA-approved oral contraceptive drugs with  
316 no therapeutic equivalent. The following apply:

317 (i) Where the FDA has approved one or more therapeutic equivalents of a contraceptive  
318 drug, device, or product, an individual or group hospital service plan is not required to include all  
319 such therapeutically equivalent versions in its formulary, as long as at least one is included and  
320 covered without cost-sharing and in accordance with this section;

321 (ii) If there is a therapeutic equivalent of a drug, device, or other product for an FDA-  
322 approved contraceptive method, an individual or group hospital service plan may provide  
323 coverage for more than one drug, device, or other product and may impose cost-sharing  
324 requirements as long as at least one drug, device, or other product for that method is available  
325 without cost-sharing; provided, however, that if an individual's attending provider recommends a  
326 particular FDA-approved contraceptive, based on a medical determination with respect to that  
327 individual, the insurer shall provide coverage, subject to a plan's utilization management  
328 procedures, for the prescribed contraceptive drug, device, or product without cost-sharing; and

329 (iii) Appeals of an adverse determination of a request for coverage of an alternative FDA-  
330 approved contraceptive drug, device or other product without cost sharing shall be subject to the  
331 expedited grievance process under section 13 of chapter 176O;

332 (2) all FDA-approved emergency contraception available over-the-counter, either with a  
333 prescription, or dispensed consistent with the requirements of section 19A of chapter 94C;

334 (3) prescription contraceptives intended to last: (i) for up to a 3-month period for the first  
335 time the prescription contraceptive is dispensed to the covered person; and (ii) for up to a 12-  
336 month period for any subsequent dispensing of the same prescription, which may be furnished or  
337 dispensed all at once or over the course of the 12 months, regardless of whether the covered  
338 person was enrolled in the policy, contract, or plan at the time the prescription contraceptive was  
339 first dispensed; provided, however, that a corporation shall not be required to provide coverage  
340 for more than one 12-month prescription in a single dispensing per plan year;

341 (4) voluntary female sterilization procedures;

342 (5) patient education and counseling on contraception; and

343 (6) follow-up services related to the drugs, devices, products and procedures covered  
344 under this subsection, including, but not limited to, management of side effects, counseling for  
345 continued adherence, and device insertion and removal.

346 (e) (1) Coverage provided under this section shall not be subject to any deductible,  
347 coinsurance, copayment or any other cost-sharing requirement, except as provided for in  
348 subsection (d)(1)(i) and (ii), or otherwise as required under federal law. Any coverage offered  
349 under this section shall not impose any unreasonable restrictions or delays in the coverage, in

350 accordance with the requirements of Chapter 176O; provided that reasonable medical  
351 management techniques may be applied to coverage within a method category, as defined by the  
352 FDA, but not across types of methods.

353 (2) Benefits for an enrollee under this subsection shall be the same for such enrollee's  
354 covered spouse and covered dependents.

355 (f) (1) The requirements of this subsection may not apply to a medical service agreement  
356 that is delivered, issued, or renewed within or without the Commonwealth that is purchased by  
357 an employer that is a church or qualified church-controlled organization, at the request of the  
358 employer.

359 (2) A church or qualified church-controlled organization that invokes the exemption  
360 provided under subsection (f)(1) shall provide written notice to prospective enrollees prior to  
361 enrollment with the plan, listing the contraceptive health care methods and services the employer  
362 refuses to cover for religious reasons.

363 (g) Nothing in this subsection shall be construed to exclude coverage for contraceptive  
364 drugs, devices, products and procedures prescribed by a provider for reasons other than  
365 contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of  
366 menopause or for contraception that is necessary to preserve the life or health of an enrollee.

367 (h) The commissioner of insurance shall ensure compliance with this chapter.

368 (i) Nothing in this subsection shall be construed to require an individual or group medical  
369 service agreement to cover experimental or investigational treatments.

370 (j) For purposes of this section, the following definitions shall apply, unless the context  
371 clearly requires otherwise:

372 “Church”, a church, a convention or association of churches, or an elementary or  
373 secondary school which is controlled, operated, or principally supported by a church or by a  
374 convention or association of churches.

375 “Provider”, an individual or facility licensed, certified, or otherwise authorized or  
376 permitted by law to administer health care in the ordinary course of business or professional  
377 practice, acting within the scope of that licensure.

378 “Qualified church-controlled organization”, described in section 501(c)(3) of the Internal  
379 Revenue Code, other than an organization which--

380 (i) offers goods, services, or facilities for sale, other than on an incidental basis, to the  
381 general public, other than goods, services, or facilities which are sold at a nominal charge which  
382 is substantially less than the cost of providing such goods, services, or facilities; and

383 (ii) normally receives more than 25 percent of its support from either (I) governmental  
384 sources, or (II) receipts from admissions, sales of merchandise, performance of services, or  
385 furnishing of facilities, in activities which are not unrelated trades or businesses, or both.

386 Contraceptive drugs, devices, or products classified as “therapeutic equivalents” means  
387 (1) they are approved as safe and effective; and (2) they are pharmaceutical equivalents in that  
388 they (a) contain identical amounts of the same active drug ingredient in the same dosage form  
389 and route of administration, and (b) meet compendial or other applicable standards of strength,  
390 quality, purity, and identity; provided further that to be considered a “therapeutic equivalent”, the

391 contraceptive drugs, devices, or products must be assigned the same therapeutic equivalence  
392 code by the FDA.

393 SECTION 6. Chapter 176G of the General Laws, as so appearing, is hereby amended by  
394 inserting after section 4O(c) the following:

395 (d) Any individual or group health maintenance contract that is issued, renewed or  
396 delivered within or without the Commonwealth and that provides benefits for outpatient  
397 prescription drugs or devices shall provide to residents of the Commonwealth and to persons  
398 having a principal place of employment within the Commonwealth coverage for all of the  
399 following services and contraceptive methods:

400 (1) all FDA-approved contraceptive drugs, devices and other products, provided that  
401 coverage shall not be required for male condoms or FDA-approved contraceptive drugs with no  
402 therapeutic equivalent. The following apply:

403 (i) Where the FDA has approved one or more therapeutic equivalents of a contraceptive  
404 drug, device, or product, a health maintenance contract is not required to include all such  
405 therapeutically equivalent versions in its formulary, so long as at least one is included and  
406 covered without cost-sharing and in accordance with this section;

407 (ii) If there is a therapeutic equivalent of a drug, device, or other product for an FDA-  
408 approved contraceptive method, a health maintenance plan may provide coverage for more than  
409 one drug, device, or other product for that method and may impose cost-sharing; provided,  
410 however, that if an individual's attending provider recommends a particular FDA-approved  
411 contraceptive, based on a medical determination with respect to that individual, the health

412 maintenance plan shall provide coverage, subject to the plan's utilization management  
413 procedures, for the prescribed contraceptive drug, device or product without cost-sharing; and

414 (iii) Appeals of an adverse determination of a request for coverage of an alternative FDA-  
415 approved contraceptive drug, device, or other product without cost-sharing shall be subject to the  
416 expedited grievance process under section 13 of chapter 176O;

417 (2) all FDA-approved emergency contraception available over-the-counter, either with a  
418 prescription, or dispensed consistent with the requirements of section 19A of chapter 94C;

419 (3) prescription contraceptives intended to last: (i) for up to a 3-month period for the first  
420 time the prescription contraceptive is dispensed to the covered person; and (ii) for up to a 12-  
421 month period for any subsequent dispensing of the same prescription, which may be dispensed  
422 all at once or over the course of the 12-month period, regardless of whether the covered person  
423 was enrolled in the plan at the time the prescription contraceptive was first dispensed; provided,  
424 however, that a corporation shall not be required to provide coverage for more than one 12-  
425 month prescription in a single dispensing per plan year;

426 (4) voluntary female sterilization procedures;

427 (5) patient education and counseling on contraception; and

428 (6) follow-up services related to the drugs, devices, products and procedures covered  
429 under this section, including, but not limited to, management of side effects, counseling for  
430 continued adherence, and device insertion and removal.

431 (e) (1) Coverage provided under this section shall not be subject to any deductible,  
432 coinsurance, copayment or any other cost-sharing requirement, except as provided for in

433 paragraph (d)(1)(i)-(ii) or as otherwise required under federal law. Any coverage offered under  
434 this section shall not impose any unreasonable restrictions or delays in the coverage, in  
435 accordance with the requirements of chapter 176O; provided that reasonable medical  
436 management techniques may be applied to coverage within a method category, as defined by the  
437 FDA, but not across types of methods.

438 (2) Benefits for an enrollee under this section shall be the same for such enrollee's  
439 covered spouse and covered dependents.

440 (f) (1) The requirements of this subsection may not apply to a health maintenance  
441 contract if that policy is purchased by an employer that is a church or qualified church-controlled  
442 organization, at the request of the employer.

443 (2) A church or qualified church-controlled organization that invokes the exemption  
444 provided under subsection (f)(1) shall provide written notice to prospective enrollees prior to  
445 enrollment with the plan, listing the contraceptive health care services the employer refuses to  
446 cover for religious reasons.

447 (g) Nothing in this subsection shall be construed to exclude coverage for contraceptive  
448 drugs, devices, products and procedures as prescribed by a provider for reasons other than  
449 contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of  
450 menopause or for contraception that is necessary to preserve the life or health of an enrollee.

451 (h) The commissioner of insurance shall ensure compliance with this chapter.

452 (i) Nothing in this subsection shall be construed to require an individual or group health  
453 maintenance contract to cover experimental or investigational treatments.

454 (j) For purposes of this section, the following words shall have the following meanings,  
455 unless the context clearly requires otherwise:

456 “Church”, a church, a convention or association of churches, or an elementary or  
457 secondary school which is controlled, operated, or principally supported by a church or by a  
458 convention or association of churches.

459 “Provider”, an individual or facility licensed, certified, or otherwise authorized or  
460 permitted by law to administer health care in the ordinary course of business or professional  
461 practice acting within the scope of that licensure.

462 “Qualified church-controlled organization”, described in section 501(c)(3) of the Internal  
463 Revenue Code, other than an organization which--

464 (i) offers goods, services, or facilities for sale, other than on an incidental basis, to the  
465 general public, other than goods, services, or facilities which are sold at a nominal charge which  
466 is substantially less than the cost of providing such goods, services, or facilities; and

467 (ii) normally receives more than 25 percent of its support from either (I) governmental  
468 sources, or (II) receipts from admissions, sales of merchandise, performance of services, or  
469 furnishing of facilities, in activities which are not unrelated trades or businesses, or both.

470 Contraceptive drugs, devices, or products classified as “therapeutic equivalents” means  
471 (1) they are approved as safe and effective; and (2) they are pharmaceutical equivalents in that  
472 they (a) contain identical amounts of the same active drug ingredient in the same dosage form  
473 and route of administration, and (b) meet compendial or other applicable standards of strength,  
474 quality, purity, and identity; provided further that to be considered a “therapeutic equivalent”, the

475    contraceptive drugs, devices, or products must be assigned the same therapeutic equivalence  
476    code by the FDA.

477           SECTION 7. Sections 1 through 6 of this act shall apply to all policies, contracts and  
478    certificates of health insurance subject to chapters 32A, chapter 118E, chapter 175, chapter  
479    176A, chapter 176B, and chapter 176G which are delivered, issued or renewed more than six  
480    months from the effective date of this act.